

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

STATE OF TENNESSEE
 STATE BOARD OF HEALTH
 Bureau of Vital Statistics
CERTIFICATE OF DEATH

1 PLACE OF DEATH
 County Putnam
 Civil Dist. 13 Registration District No. 47213 File No. _____
 or Village Silverpoint Primary Registration District No. _____ Registered No. 14
 or City _____ (No. _____, St.; _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel Jacob Carter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m **4 COLOR OR RACE** white **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** widower
 (Write the word)

6 DATE OF BIRTH April 16, 1912
 (Month) (Day) (Year)

7 AGE 14 yrs. 9 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Tram Driver
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Smith Co. Tenn

10 NAME OF FATHER George Washington Carter

11 BIRTHPLACE OF FATHER (State or country) W. Va

12 MAIDEN NAME OF MOTHER Letha Farmer

13 BIRTHPLACE OF MOTHER (State or country) Smith Co. Tenn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 16, 1916
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1915, to Nov. 30, 1916,
 that I last saw him alive on Nov. 30, 1916,
 and that death occurred, on the date stated above, at _____ m.
 The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis
 (Duration) 9 yrs. 7 mos. 8 ds.

Contributory _____
 (SECONDARY) (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) L. L. Love M. D.
Dec 21, 1916 (Address) Silverpoint 272

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted, if not at place of death? _____
 Former or usual residence _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) H. A. Carter
 (Address) Silverpoint, Tenn

15 Filed Dec 21, 1916 G. A. Hall
 REGISTRAR

19 PLACE OF BURIAL OR REMOVAL Moss Cemetery **DATE OF BURIAL** Dec 17, 1916

20 UNDERTAKER A. J. Peltig **ADDRESS** Smithville